CHAPTER
4

PREPARING FOR ENROLLMENT/DISENROLLMENT

Freedom of Choice

Once it is determined that an individual has needs that could likely be met either in an institution or in the community with the provision of HASCI Waiver services, the Service Coordinator must:

- Inform the individual, or his/her legal guardian, of the feasible alternatives under the HASCI Waiver,
- Give the individual, or his/her legal guardian, a choice of institutional services or home and community based services (HASCI Waiver), and
- Inform the individual, or his/her legal guardian, of his/her right to request a fair hearing.

Once the Service Coordinator has received notification that an individual has a Waiver slot, the first step is to have him/her sign the Freedom of Choice Form (HASCI Form 2). The Freedom of Choice Form reflects the individual's written choice to participate in the Waiver. The Freedom of Choice Form must be signed by the individual if he/she is a legal adult (age 18 or over and not adjudicated incompetent) or a legally responsible adult (parent or guardian of a child under the age of 18, or guardian of an adult who is adjudicated incompetent).

Note: The only exception to making a written choice (by signing the Freedom of Choice Form) is when an individual is not capable of signing. In these cases, services are not denied if written choice cannot be obtained. The reason(s) for the absence of signed choice must be carefully documented by the Service Coordinator **on the Freedom of Choice Form and in the service notes**. In addition, a responsible party should sign the Freedom of Choice Form in these situations if he/she will assume the responsibility of working with the Service Coordinator.

The Service Coordinator and the individual must discuss the service options available through the Waiver versus institutional placement. After this is discussed, the individual must mark on the Freedom of Choice Form that he/she chose to receive Waiver services in the community or institutional placement. The Service Coordinator and the individual must sign and date the form.

The Service Coordinator must document in the service notes the meeting with the individual and/or the family and the discussion of Waiver services. The documentation should clearly state that the individual chose to receive services in the community (via the Waiver) as opposed to institutional placement (ICF/MR or NF). If the individual chooses "institutional placement" over Waiver services in the community, the Service Coordinator must explain that this in no way guarantees placement in an institution.

Note: **The Freedom of Choice Form must always be completed before the enrollment date in the Waiver. A copy of the original form, signed by the individual and/or legal guardian, must remain in the working file as long as the individual is participating in the Waiver.**

Note: If the parent or guardian of a minor signs the Freedom of Choice Form, the individual must sign it when he/she reaches the age of majority (age 18) if he/she has not been adjudicated incompetent. The individual may sign and date the original Freedom of Choice Form or sign and date a new form.

The Service Coordinator must explain to the individual his/her right to choose the provider(s) of service(s) and his/her appeal rights and document the discussion in the individual(s) record. The individual and Service Coordinator must sign the Acknowledgement of Choice and Appeal Rights (Form 19). The Acknowledgement of Choice and Appeal Rights must be signed initially when the Freedom of Choice is signed (**prior to enrollment**). Thereafter, the Acknowledgement of Choice and Appeal Rights **must be completed each year at the annual Plan meeting**. A copy of the Acknowledgement of Choice and Appeal Rights must be given to the individual and the original placed in the individual's file. This must be documented in the service notes.

The Service Coordinator must explain to the individual his/her rights and responsibilities as a HASCI Waiver recipient. The individual must sign the Acknowledgment of Rights and Responsibilities (Form 20) **prior to enrollment** and receive a copy of the form. This must be documented in the service notes.

The Acknowledgement of Rights and Responsibilities (Form 20) will only be completed initially **(one-time)** when the Freedom of Choice Form and Acknowledgment of Choice and Appeal Rights is completed and will not be required annually. For individuals already enrolled in the HASCI Waiver, the Acknowledgement of Rights and Responsibilities must be completed at the annual Plan meeting (one-time). If the individual does not abide by the rights and responsibilities as noted in the document, the Service Coordinator must document in the file any concerns, problems and the plan to resolve the problems with the individual and service providers. The Service Coordinator must review the Acknowledgement of Rights and Responsibilities Form (Form 20) again with the HASCI Waiver participant. The Service Coordinator should proceed with getting a new HASCI Form 20 signed by the HASCI Waiver participant in an effort to alleviate/resolve the problems. This must be documented in the service notes. If the individual does not abide by the rights and responsibilities as noted in the document, it may lead to the termination of HASCI Waiver services**.**

Note: If the individual is not abiding by the rights and responsibilities as a HASCI Waiver participant, the HASCI Division must be notified.

If the individual does not want to participate in the HASCI Waiver, the individual must sign the Statement of Individual Declining Waiver Services (HASCI Form 3). The Service Coordinator must explain that declining Waiver services does not directly affect eligibility for services through SCDDSN. The individual should understand, however, that the continuations of any state-funded family support funds are subject to the availability of funds. The Service Coordinator must also explain that declining Waiver services at this time does not prohibit the individual from re-applying in the future. A copy of HASCI Form 3 must be faxed immediately to the HASCI Division. The original should be placed in the individual's file and a copy given to the individual/legal guardian.

Initial Level of Care Evaluations

To be eligible for Waiver services, an individual must be determined otherwise eligible for placement in an ICF/MR or Nursing Facility. **The potential participant must be evaluated and meet Level of Care within 30 days prior to his/her enrollment in the Waiver.**

Initially, the Service Coordinator must determine whether the individual should be evaluated using the ICF/MR or Nursing Facility Level of Care. Service Coordinators should use the following criteria for guidance:

A. Individuals with brain injury that occurred prior to the age of 22 may be referred to CLTC for a NF LOC or to the Consumer Assessment Team (CAT) for an ICF/MR LOC determination. In order to refer the individual to CAT for an ICF/MR LOC determination, the individual must meet the criteria for related disability. In order to determine the most appropriate Level of Care, the Service Coordinator should consider the age of onset, the cognitive deficits and the predominant functional limitations and consult with his/her supervisor.
B. If the brain injury occurred after age 22 the ICF/MR is not an option and the NF level of care must be requested from CLTC.
C. All individuals with spinal cord injury, regardless of the age of onset, should be assessed using the NF Level of Care.
D. Individuals with similar disability or dual injuries may be referred to CLTC for a NF LOC or to CAT for an ICF/MR LOC determination. In order to refer the individual to CAT for an ICF/MR LOC determination, the individual must meet the criteria for related disability. This means the onset is before age 22. In order to determine the most appropriate Level of Care, the Service Coordinator should consider the age of onset, the cognitive deficits and the predominant functional limitations and consult with his/her supervisor.

Initial ICF/MR Level of Care Evaluations

Initial ICF/MR Level of Care Evaluations are completed by the DDSN Office of Consumer Assessment/Consumer Assessment Team (CAT). The initial determination is requested by completing the Referral for ICF/MR Level of Care

Determination Form (HASCI Form 4) and forwarding it along with supporting documentation about the potential participant to the Office of Consumer Assessment.

Once received, CAT will hold a meeting or staffing to determine the individual's Level of Care. (***Note:*** If the Service Coordinator wishes to attend the staffing, he/she must notify CAT in writing of the desire to attend.) CAT will render a decision regarding Level of Care within ten (10) working days of receipt of the request.

When the determination has been made, CAT must certify that the person does or does not meet ICF/MR Level of Care. This is done by completing the ICF/MR Level of Care Determination form and the SCDDSN Level of Care Certification Letter. The original Level of Care Certification Letter, with the procedure for appeals printed on the reverse side, will be mailed to the individual and/or family. A copy of the Certification Letter, LOC determination and Staffing Report will also be sent to the Service Coordinator. These documents should be maintained in the individual's working file.

Enrollment in the HASCI Waiver must be within thirty (30) days of the determination of Level of Care. If 30 days pass between the level of care determination and enrollment, a new SCDDSN Certification must be issued. If a new letter is needed CAT may:

- Allow the Service Coordinator to request the issuance of a new Certification Letter by telephone. If this option is used, the Service Coordinator must document in the service notes the date and time of the call to CAT, the name of the person contacted, the name of the potential participant discussed, the date of the initial determination of Level of Care (date on the Level of Care Determination for ICF/MR form), **and a statement about whether or not the person's condition has changed since the completion of the initial Level of Care Determination for ICF/MR.** Based on the information provided during the telephone call, CAT may request that a copy of the initial ICF/MR LOC determination form, the Certification Letter and a new Form 4 be resubmitted via fax along with a statement requesting issuance of a new Certification Letter. The statement regarding whether or not the person's condition changed must also be faxed to CAT. Upon receipt, CAT will issue a new Certification Letter that will be mailed to the potential participant and a copy to the Service Coordinator.
- Request that a new Level of Care packet be submitted to include all relevant new information that may affect the consumer's need for supervision at the ICF/MR level.

Note: If an ICF/MR LOC has been recertified, it cannot be recertified again. If the individual is not enrolled in the HASCI Waiver within thirty (30) days of the recertification, a new Level of Care packet must be submitted to the Consumer Assessment Team.

Note: All communication with CAT regarding ICF/MR Level of Care re-evaluations must be clearly documented in the individual's file.

The method used for issuance of a new Certification Letter is at the discretion of CAT.

Adverse ICF/MR Level of Care Determination for Initial ICF/MR Evaluations

- If CAT determines the individual does not meet Level of Care, CAT will forward copies of the completed LOC determination and supporting documentation to the Service Coordinator. The individual/family must be provided with the SCDDSN Reconsideration/Appeals process.

Initial Nursing Facility Level of Care Evaluations

Initial Nursing Facility Level of Care Evaluations will be conducted by Registered Nurses at the local Community Long Term Care Office. The Service Coordinator must forward the following information to the HASCI Contact at the CLTC Office:

(1) DDSN/CLTC Transmittal Form for Nursing Facility Level of Care (HASCI Form 7). **Note: At the time of the request for the initial Nursing Facility Level of Care Evaluation the Service Coordinator must inform the Nurse from CLTC if the individual is currently hospitalized.**

(2) Consent Form for Level of Care Evaluation (DHHS Form #121).

(3) Completed pages 1, 2 and 3 of the SCDHHS Form 1718.

The Service Coordinator must discuss these requirements with the individual and he/she must sign a consent form (SCDHHS Form 121) prior to requesting a Level of Care Evaluation. (***Note:*** The Consent Form should be completed at the same HV where the Freedom of Choice is discussed.)

Note: A list of each of the HASCI Contacts at the various CLTC Offices is attached to this section.

The Nurse from CLTC will complete the Level of Care during a home visit or phone contact within 15 working days of the referral. **Note: The Nurse from CLTC will complete the Level of Care during a hospital visit if the individual is hospitalized at the time of the request. The Service Coordinator must work closely with CLTC regarding the discharge of the individual as the Level of Care must be updated by the Nurse from CLTC upon individual's discharge from the hospital).** The completed 1718 and the DDSN/CLTC Transmittal Form (HASCI Form 7 will be returned to the Service Coordinator.

If the individual does not meet Level of Care, the Service Coordinator must notify the individual/family by completing the Nursing Facility Level of Care Notification Letter

(HASCI form 7A). It must be mailed to the individual and/or family with **information on** the SCDDSN Reconsideration Process and SCDHHS Medicaid Appeals Process.

As stated earlier, individuals must be enrolled in the HASCI Waiver within 30 days of the initial Level of Care evaluation. If the individual is not enrolled in the Waiver within 30 days of the initial Level of Care evaluation, the Service Coordinator must forward the DDSN/CLTC Transmittal Form for Nursing Facility Level of Care (HASCI Form 7) to CLTC along with the Consent Form (DHHS Form #121) and completed pages 1, 2, and 3 of the SDDHHS Form 1718 to request a new/updated evaluation. ***Note: It is not necessary to request this update every 30 days for individuals who are awaiting enrollment for longer periods of time. It is only required that one update be completed which is within 30 days prior to that individual's enrollment.***

Level of Care Re-evaluations

Level of Care Re-evaluations must be completed for all HASCI Waiver participants as frequently as needed, but at least every 365 days (the day before the LOC was completed during the previous year). If a Service Coordinator determines that an individual's condition or functioning has changed significantly, and the individual may no longer meet Level of Care, an evaluation should be completed at that time. **If a Level of Care Re-evaluation is not completed within 365 days, Waiver services may not be billed for the individual.**

ICF/MR Level of Care Re-Evaluations

- ***ICF/MR Level of Care Re-evaluations will be completed by the DDSN Head and Spinal Cord Injury Service Coordination staff except for individuals that are eligible on a time-limited basis. For individuals that have time-limited eligibility, the same information that is required for an initial Level of Care evaluation along with the most recent LOC determination and Certification Letter must be submitted to CAT.***
- Re-evaluations will consist of, at a minimum, a review of the most recent psychological, social and medical information as well as the individual's most recent Plan. Based on the review of this information, the Service Coordinator will complete the Level of Care Determination for ICF/MR using the Guidelines for Completion of the Level of Care Determination for ICF/MR. The Service Coordination Supervisor or Executive Director of the local DSN Board must review all decisions. The Service Coordination Supervisor should be consulted about the procedure of supervisory review of Level of Care re-evaluations.
- The Service Coordinator will then verify that the individual does/does not meet Level of Care by completing the Level of Care Determination Form and the SCDDSN Level of Care Certification Letter. **The effective date of the Level of Care is the date that the evaluation is completed and is good for up to 365 days.** The

expiration date is 365 days from the effective date. (Example: Effective: 10/15/04, Expires: 10/14/05).

- The Service Coordinator may certify the ICF/MR Level of Care for less than one year if it is felt that the individual's condition warrants a more frequent review. The reason for a change in length of the certification period must be documented in the individual's file.
- If the individual is found to meet the ICF/MR Level of Care, the Service Coordinator must mail the SCDDSN Certification Letter to the individual/family within two (2) working days of completion. A copy of the letter along with the ICF/MR Level of Care determination form must be mailed to the Central Office HASCI Division. A copy must be kept in the individual's file.
- The Service Coordinator must enter the effective date of the LOC determination/certification onto the Waiver Tracking System. This should be completed within one (1) working day of the determination. To complete this update in the Waiver Tracking System (WTS), select the enrollment menu (ENMEN), then (ENLDT) and enter the individual's name or ID number. Enter the effective date of the re-evaluation/certification.

Adverse ICF/MR Level of Care Determination for ICF/MR LOC Re-evaluations:

- If the Service Coordinator determines that the individual does not meet ICF/MR Level of Care, the Service Coordinator must submit all information used to make this determination to CAT along with the HASCI Form 4, the completed Level of Care Determination Form, and the Certification Letter within 2 working days of the date of the determination. CAT must complete a review of the determination **prior to the expiration date of the current certification.**
- If CAT agrees with the determination that the individual does not meet the ICF/MR Level of Care the LOC determination will be signified by the presence of the signature of the designated CAT staff underneath the Service Coordinator's signature on the Certification Letter. CAT will then notify the Service Coordinator who will refer the individual for a Nursing Facility Level of Care Evaluation. **The HASCI Division must be notified of the request and outcome of the NF Level of Care determination.**
- If CAT does not agree with the Service Coordinator's determination, CAT will have the authority to overrule the determination and eligibility will continue. CAT will signify it's disagreement with the Service Coordinator's decision by completing a new Level of Care Determination for ICF/MR and Certification Letter. CAT will be responsible for notifying the Service Coordinator, the participant or his/her family or guardian and the SCDDSN Central Office/HASCI Division. The Service Coordinator must enter the LOC determination date onto the Waiver Tracking System.
- If the individual does not meet the ICF/MR LOC or the NF/LOC, the individual/family must be provided with the SCDDSN Reconsideration/Appeals process.

- All documentation must be kept in the individual's file (this information cannot be purged).

Nursing Facility Level of Care Re-evaluations

- ***The HASCI Service Coordinator will complete Nursing Facility Level of Re-evaluations.*** Service Coordinators will complete the SCDHHS Form 1718 using the Assessment and Level of Care Manual that is attached to this section.
- A **home visit** with the Waiver participant is required to complete the Level of Care Re-evaluation. (***Note:*** **This means that a Level of Care Re-evaluation cannot be completed unless the Service Coordinator meets with the individual in his/her home. It is not acceptable to complete Level of Care Re-evaluations with family members when an individual is not present. Also, Level of Care Re-evaluations should not be completed on an individual who is staying away from home for a temporary period. This includes individuals that are hospitalized.)** **The HASCI Division must be notified if an individual has been hospitalized or is away from home temporarily.**
- Service Coordinators are encouraged to consult medical professionals and **obtain recent medical reports prior to making a home visit with the individual.**
- When the re-evaluation is complete, a **copy** of the entire SCDHHS Form 1718 and the HASCI form 6 must be sent to the DDSN Central Office, HASCI Division.
- The Service Coordinator must enter the effective date of the LOC determination/certification onto the Waiver Tracking System. This should be completed within one (1) working day of the determination. To complete the update in the Waiver Tracking System (WTS), select the enrollment menu (ENMEN), then (ENLDT) and enter the individual's name or ID number. Enter the effective date of the re-evaluation/certification.

Adverse NF Level of Care Determination for NF Level of Care Re-evaluations:

- If the Service Coordinator determines that the individual does not meet NF/Level of Care, the Service Coordinator must notify the HASCI Division within 2 working days of the date of the determination. The HASCI Division must be notified to discuss the outcome of the NF/LOC and complete a review of the determination with the Service Coordinator and/or Service Coordination Supervisor. This must occur prior **to the expiration date of the current LOC determination.**
- If the HASCI Division determines that the individual continues to meet LOC, the Service Coordinator/Service Coordination Supervisor will update the DHHS Form 1718 and HASCI Form 6 and resubmit the information to the HASCI Division.
- If the HASCI Division accepts the adverse LOC determination, the individual/family must be provided with the SCDDSN Reconsideration/Appeals process.
- **All documentation of the decision must be kept in the individual's file (this information cannot be purged).**

Note: As stated in the Nursing Facility Level of Care Assessment Manual, a Level of Care cannot be determined without staffing it with a Supervisor. When completing NF Level of Care re-evaluations, Service Coordinators must ensure that the individual's file clearly documents a "staffing" with his/her supervisor to determine the individual's Level of Care. In addition, the Service Coordination Supervisor is required to initial the 1718 signifying his/her participation in the Level of Care determination. The staffing must take place within two (2) working days of the home visit with the individual. **The date the NF Level of Care re-evaluation is "staffed" with his/her supervisor is the Level of Care determination date.**

Medicaid Eligibility

Individuals must be Medicaid eligible in order to receive services through the HASCI Waiver. There are a number of categories that may be used to establish Medicaid eligibility.

Service Coordinators should assist individuals with applying for State Plan Medicaid as early as possible. Since HASCI Waiver participation is only required for Category 15 Medicaid, the application for other categories can be made at any time. ***Individuals who meet eligibility criteria of other categories should not be referred for Medicaid eligibility under Category 15.***

There are some Medicaid programs and/or categories that cannot overlap with participation in the HASCI Waiver. The RSP (Recipient Special Program) Overlap Table is included as an attachment to this chapter to outline the overlap criteria.

Use of the DHHS Form 118-A

The DHHS Form 118-A must be completed for all individuals entering the HASCI Waiver (the Form 5 and Form 5-A is obsolete). The DHHS Form 118-A verifies the Level of Care date and the date the individual entered the HASCI Waiver (services begin date and enrollment date). The Service Coordinator is responsible for completing Part I-Client Information and submitting the form to the Regional Medicaid Sponsored Worker. The Regional Medicaid Sponsored Worker is responsible for completing Part II of DHHS Form 118-A and sending it to the Service Coordinator. The Service Coordinator is responsible for completing Part III-Notification of Waiver Services of the DHHS Form 118-A and submitting the form to the Regional Medicaid Sponsored Worker. A copy of the DHHS Form 118-A must be sent to the HASCI Division upon completion.

Typically, Part I and Part III of the DHHS Form 118-A should be completed by the Service Coordinator, meaning the form will be filled out twice by the Service Coordinator. There may be instances when the DHHS Form 118-A may be completed more than two (2) times. For example, should the individual become hospitalized during the enrollment process and he/she will not be enrolled in the HASCI Waiver within 30 days of the initial Level of Care determination and a new LOC will be required, he/she must notify the Regional Medicaid Sponsored Worker **immediately**.

Note: The Service Coordinator will be responsible for completing the DHHS Form 118-A verifying the current LOC determination date and the date the individual entered the HASCI Waiver (date services began) and sending the 118-A to the Regional Medicaid Sponsored Worker. The HASCI Division must be notified of any concerns regarding completion of the DHHS Form 118-A.

Individuals Entering the Waiver as a New Category 15 Participant and Ineligibility

If the individual is entering the Waiver as a new category 15 participant, the individual must meet SSI disability criteria. To be eligible for category 15, the individual must be in a Waiver.

If the individual is found eligible as a new category 15 participant, the Service Coordinator will proceed with enrollment and development of the budget. A copy of the completed DHHS Form 118-A must be forwarded to the DDSN Central Office, HASCI Division with the pre-enrollment form (HASCI Form 9). ***Note:*** **This category of Medicaid requires participation in a Home and Community Based Waiver for 30 days before Medicaid is active. Coverage will be retroactive to the first day of the month in which services are received.**

If the individual is found **ineligible for Medicaid**, a Waiver Termination Form (HASCI Form 8) must be completed and forwarded to the DDSN Central Office, HASCI Division and a copy to the Regional Medicaid Sponsored Worker.

Use of HASCI Form 5B-Medicaid Income Trust

The HASCI Form 5B was specially created for those individuals receiving Category 15 Medicaid through an Income Trust. The Form 5-B must be completed and forwarded to DHHS after an individual is enrolled in the Waiver under this circumstance. The cost of Waiver Services for Month 1, 2, and 3 must be completed and the "projected" monthly cost of care beginning with month 4. The HASCI Form 5B must be sent to the SCDHHS Division of Eligibility Policy and Oversight and a copy faxed to the HASCI Division.

Determining a Start Date

Once an individual has signed the Freedom of Choice Form, the Acknowledgement of Choice and Appeal Rights, the Acknowledgement of Rights and Responsibilities, had a Level of Care Evaluation completed, and is eligible for Medicaid, the Service Coordinator must work with the individual to target a start date for services. The Service Coordinator must coordinate the start date for services with the HASCI Division. **The enrollment date in the HASCI Waiver will always be the first day in which an individual begins receiving services funded through the HASCI Waiver.**

If an individual is moving from an institutional setting, the Waiver enrollment date should be the date that he/she moves out of the institution and begins receiving Waiver services. **An individual may not receive Waiver services while residing in any institutional setting (hospital, nursing home, jail, etc.).**

When an individual is transferring from one waiver to another, coordination between Service Coordinators/Case Managers is extremely important. Staff must work together to ensure that the individual does not have any break in service. When an individual is allocated a Waiver slot, the Service Coordinator should begin working with the

individual's CLTC Case Manager to identify a termination date from the current Waiver and a start date in the HASCI Waiver. The individual must be terminated from the current Waiver on one day and enrolled in the HASCI Waiver on the next day. **The transfer date must be communicated in writing to the other Service Coordinator/Case Manager prior to the transfer using the HASCI Form 10.** This form must also be forwarded to the SCDHHS Regional Medicaid Sponsored Worker and to the HASCI Division. An individual cannot be enrolled in two Waivers at the same time. Enrollment in the new Waiver will always be contingent upon termination/disenrollment from the original Waiver program.

Note: **CLTC Case Managers will not backdate terminations so timely coordination between both Waivers is extremely critical.**

Note**: If an individual has received UAP Attendant Care Services through CLTC, the Service Coordinator must follow the procedures for UAP Attendant Care Services through DDSN (prior to enrollment) to ensure that the individual does not have any break in UAP Attendant Care Services.**

Pre-enrollment Form

Once a target start date has been established, the Service Coordinator must complete the HASCI Waiver Pre-enrollment Form (HASCI Form 9) and forward to the DDSN Central Office, HASCI Division. A completed DHHS Form 118-A must accompany the Pre-enrollment Form for individuals who will be receiving Medicaid eligibility after 30 days participation in the Waiver (New category 15 participant). Upon receipt of the Pre-enrollment Form, the HASCI Division will set up the individual in the Waiver Tracking System (WTS) as pending enrollment. The HASCI Division will be responsible for updating the Waiver Tracking System noting awaiting enrollment and enrolled (currently enrolled) and notify the Service Coordinator.

Note: The HASCI Division only requires the DHHS Form 118-A accompany the Pre-Enrollment Form when the individual is a new category 15 participant. For all other individuals, the DHHS Form 118-A must be sent to the HASCI Division when completed. The HASCI Division will verify through MMIS that the individual is a current Medicaid participant.

Reasons for Termination/Disenrollment

It may be necessary to terminate (disenroll) individuals from the HASCI Waiver for various reasons. **An individual must be terminated/disenrolled from the HASCI Waiver when:**

- The individual dies.
- The individual is admitted to a Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF/MR).
- The individual no longer meets Level of Care.
- The individual is no longer eligible for Medicaid.

- The individual voluntarily withdraws from the HASCI Waiver (when an individual no longer wishes to receive Waiver services). Individuals wishing to withdraw from the HASCI Waiver must sign a Voluntary Termination Statement (HASCI Form 16).
- The individual no longer receives HASCI Waiver services. This means that the individual has not received HASCI Waiver services for thirty (30) consecutive days in one month. The termination date from the Waiver is the last day of the month following a month in which a Waiver service was received. (Example: If an individual receives a Waiver service on March 17 and receives no other Waiver services before April 30, then the individual will be terminated effective April 30.)
- The individual moves out of state.

When it becomes necessary for an individual to be terminated (disenrolled) from the HASCI Waiver, the Service Coordinator is responsible for giving the individual prior written notification and to provide information on the SCDDSN Reconsideration Process and SCDHHS Medicaid Appeals Process. This notification is not necessary when it has been verified that the individual has died or when the individual has moved out of state. This should be documented in the individual's file.

Procedures for Waiver Termination

When the Service Coordinator determines that an individual must be terminated (disenrolled) from the HASCI Waiver, he/she must:

- Notify the individual of his/her termination (disenrollment) and right to appeal using the SCDDSN Reconsideration Process and SCDHHS Medicaid Appeals Process.

  The Service Coordinator is responsible for mailing a notice **at least ten (10) calendar days <u>before the date of action</u>**. If the individual requests a reconsideration of an adverse decision before the date of action, SCDDSN may not terminate services until a decision is rendered. If the State's action is sustained, the State may institute recovery procedures against the individual/recipient to recoup the cost of any services furnished the individual/recipient, to the extent they were furnished solely by reason of the appeal. (For example, if the individual is hospitalized and will continue to be hospitalized for 30 consecutive days within a month, the Service Coordinator must notify the individual 10 calendar days before the date of termination of services).
- Notify all providers that Waiver services for the individual must be terminated by completing the Notice of Termination of Service Form (HASCI Form 11).
- Determine actual units of budgeted services received by the individual and update the Waiver Tracking System with actual end date for services within two (2) working days.
- If the individual is receiving day habilitation or prevocational services, the STS must be updated to reflect the individual is no longer receiving HASCI Waiver funding for his/her day services.

- Update the individual's Plan to reflect actual units of services received through the HASCI Waiver.
- Complete the HASCI Waiver Termination Form (HASCI Form 8) and forward it to the DDSN Central Office, HASCI Division noting the reason for termination **within two (2) working days**. A copy of this form must be sent to the SCDHHS Regional Medicaid Sponsored Worker.

Note: If the HASCI Waiver Termination Form (HASCI Form 8) is not completed within 2 working days and forwarded to the HASCI Division, the DSN Board may be responsible for payment of Medicaid State Plan services.

Note: If an individual is eligible for Medicaid under Category 15, termination from the Waiver will result in loss of Medicaid eligibility. Service Coordinators must ensure that this is communicated in writing to individuals and/or their families. A copy of the communication is maintained in the individual's file.

The Central Office HASCI Division will be responsible for officially terminating (disenrolling) the individual from the HASCI Waiver and forwarding relevant information to SCDHHS.

The following exceptions apply to termination/disenrollment and allow an individual to be terminated/disenrolled from the HASCI Waiver, however, retain his/her Waiver slot on a temporary basis (Procedures for Termination must be followed and the HASCI Division must be notified of the exceptions):

- **A Medicaid recipient's eligibility has been interrupted for more than 30 calendar days; however, Medicaid eligibility should be reinstated within 90 calendar days. The slot will be held up to a period of 90 calendar days to allow time for the Medicaid eligibility to be reinstated. If Medicaid is reinstated within 90 calendar days, procedures for enrollment must be followed (completing Freedom of Choice, Form 19, Form 20, requesting a Level of Care and completing DHHS Form 118-A). If Medicaid is not reinstated within 90 calendar days, the slot will be revoked and the Service Coordinator must complete a new Request for a HASCI Waiver Slot (Form 1).**

- **A HASCI Waiver recipient has not received a service for 30 calendar days due to provider non-availability. The individual may retain the slot up to 90 calendar days to allow for a provider to be located to provide the needed service(s). If a provider is located within 90 calendar days, the individual may be enrolled without reapplying for a HASCI Waiver slot. The Service Coordinator must follow the procedures for enrollment including completion of the DHHS 118-A. If a provider has not been located within 90**

calendar days, the slot will be revoked and the Service Coordinator must complete a new Request for a HASCI Waiver Slot (Form 1).

- **A HASCI Waiver recipient has entered the hospital for an extended period of time exceeding 30 days within a calendar month and he/she will require HASCI Waiver services upon discharge from the hospital. The individual may retain the slot up to 90 calendar days. If the individual is discharged from the hospital within the 90 calendar days, the individual may be enrolled in the waiver without reapplying for a HASCI Waiver slot. The Service Coordinator must be directly involved with discharge planning. The Service Coordinator must follow the procedures for enrollment including completion of the DHHS Form 118-A. If the individual is not discharged from the hospital within 90 calendar days the slot will be revoked and the Service Coordinator must complete the Request for a HASCI Waiver Slot reapplying for HASCI Waiver services.**

- **A HASCI Waiver recipient has entered a nursing facility as a "temporary admission" exceeding 30 days within a calendar month and he/she will require HASCI Waiver services upon discharge from the nursing facility. The individual may retain the slot up to 90 calendar days. If the individual is discharged from the nursing facility within the 90 calendar days, he/she may be enrolled in the waiver without reapplying for a HASCI Waiver slot. The Service Coordinator must be directly involved with discharge planning. The Service Coordinator must follow the procedures for enrollment including completion of the DHHS Form 118-A. If the individual is not discharged from the nursing facility within 90 calendar days the slot will be revoked and the Service Coordinator must complete the Request for a HASCI Waiver slot reapplying for HASCI Waiver services.**

Note: In the exceptions above, the individual will be terminated/disenrolled from the HASCI Waiver; however, he/she will not lose his/her Waiver slot. The Waiver slot will be held up to 90 calendar days.

CLTC MEDICAID ELIGIBILITY FACT SHEET

Revised January 1, 2008

PROGRAM	AGENCY	CATEGORICAL REQUIREMENTS	FINANCIAL REQUIREMENTS		PROGRAM BENEFITS **
			INCOME LIMITS	RESOURCE LIMITS	
SSI *Cat 80,16,81* SSI/NH *Cat 54*	Social Security Admin.	Must be aged (65+), blind, or totally & permanently disabled. (HIV+ may be determined presumptively disabled.)	Eligibility is on individual basis; individual income limit ≤ $637; if both members of married couple qualify, couple income limit ≤ $956.	$2,000 individual $3,000 couple ×	Cash pymt. based on income; individual w/no income gets $564/month; Medicaid eligibility; CLTC & NH if meet LOC.
Low Income Family (LIF) *Cat 58, 59* TM *Cat 11*	DHHS County Office	LIF = Family must have child in home under age 18 (or under age 19 if in secondary school). Transitional Medicaid (TM) has same categorical requirements as LIF.	Based on family size & income; net income ≤ $860 for family of 4 after disregards & deductions. Medicaid benefits extended 18-24 mos. due to employment.	Countable Resource Limit of $30,000 per BG 36 mo. look back required. & *	No cash pymt.; Medicaid eligibility; CLTC HIV/AIDS all ages; CLTC E/D age 18+; VENT age 21+; meet appropriate LOC.
Working Disabled *Cat 40*	DHHS State Office	Must meet SS modified disability criteria and be employed.	Family income below 250% of poverty. (family of 4 ≤ $4,302/mo.) Individual unearned income at or below 100% of the Federal Poverty Level.	$4,000 individual & *	Medicaid eligibility; CLTC E/D age 18+; VENT age 21+; HIV/AIDS all ages.
OCWI *Cat 12, 87* PHC *Cat 88*	DHHS County Office	OCWI = Children under age 1 & pregnant women. Partners for Healthy Children (PHC) = Children under ages 1 thru 18	Children under age 1 & pregnant women, 185% of poverty (family of 4 ≤ $3,184/mo.); Children 1 - 18 at 150% of poverty (family of 4 ≤ $2,581/mo.)	Countable Resource Limit of $30,000 per BG 36 mo. look back required. & *	Medicaid eligibility; CLTC HIV/AIDS all ages; CLTC E/D age 18+; VENT age 21+; & meet appropriate LOC.
Foster Child *Cat 13, 31, 51, 60*	DHHS County Office	Children under age 21; supported in part by the state; live in foster home or private institution.	Generally established on individual basis; individual limit ≤ $425/month.	$2,500 & *	Medicaid eligibility; CLTC HIV/AIDS all ages; CLTC E/D ages 18+.
OSS *Cat 85* SSI/OSS *Cat 86*	DHHS County Office	Live in licensed residential care facility & meet SSI eligibility criteria except for income.	Individual net income limit ≤$1,120/month.	$2,000 & *	State payment for board & care; Medicaid eligibility; CLTC if meets LOC.
MAO: CLTC *Cat 15* NH *Cat 10*	DHHS County Office	Must meet SSI disability criteria (or age 65+ or blind), meet LOC & reside in nursing facility or participate in a CLTC waiver for 30 consecutive days. See Note.	Individual income ≤ $1,911/month ***; maximum income allocation under Spousal Impoverishment Provision ≤ $2,610/month.	$2,000 * !! Maximum spousal resource allocation $66,480	Medicaid eligibility; CLTC E/D, HIV/AIDS or VENT or NH if meets appropriate LOC. *Note:* Receiving CPCA does not qualify client for MAO; to be *Cat 15*, must be in a waiver.
ABD *Cat 32* ABD-NH *Cat 33*	DHHS County Office	Must meet SSI disability criteria (or 65+ or blind); income below 100% poverty level.	Individual income ≤ $851/month. Couple income ≤ $1,141/month.	$4,000 individual $6,000 couple * #	Medicaid eligibility; CLTC & NH if meet LOC.

QDWI *Cat 50*	Qualified Disabled Working Individual-*Not Eligible for Any Medicaid or CLTC Services*	×	Look back for transfer of resource is not required.
SLMB *Cat 48, 52*	Special Low Income Medicare Beneficiaries - *Not Eligible for Any Medicaid or CLTC Services*	*	Home property excluded if equity value is less than $500,000.
Ribicoff *Cat 91*	Most individuals previously included in this category are now included in Partners for Healthy Children - *Cat 88*; however, some still show as *Cat 91*.	**	Medicaid eligibility means all regular Medicaid state plan services, including Children's PCA.
Family Plng *Cat 55*	Receive only family planning services. Income limit: 185% of federal poverty level. *Not Eligible for CLTC or Regular Medicaid*	***	If client income is above MAO limit, possible income trust - Apply *at DHHS*.
TEFRA ☺ *Cat 57*	Children age 18 & under who: live at home, meet SSI disability and NH, ICF or hospital LOC, have individual income ≤ $1,911/mo. & estimated cost of care is less than institutional. Parent's income is not counted. *Apply at DHHS.*	#	For NH, must verify resources were not transferred within the preceding 36 months; *use CSD and hold services for DHHS response.*
	☺ If enrolled into the waiver, the category may convert to MAO Cat. 15; however it is not required. Category could remain Cat. 57.	&	For CLTC - Must verify resources were not transferred within the preceding 36 months; *use CSD with LOC. Services may be authorized for Cat. 85.* For Cat. 86, must verify resources were not transferred within the preceding 36 months; *use CSD and hold services for DHHS response.*
NOTE:	Individuals who must be in hospital for 30 consecutive days, are age 65+ or totally and perm. disabled may be eligible as MAO General Hospital -*Cat14. Apply at DHHS.*	!!	Resource verification part of Medicaid application process.

SOUTH CAROLINA STATE MEDICAID PROGRAM: MAJOR COVERAGE GROUPS (Effective 3/1/07)

	Eligible Population	Income Limits	Resources	Benefits
(O) AGED,BLIND DISABLED UNDER 100% POVERTY (32)	Aged (65+), blind, or permanently disabled	100 percent of poverty. Individual limit $851/mo. Couple limit $1,141/mo.	Resources below $4,000 for an individual and $6,000 for a couple	Medicaid
(M) QMB (90)	Must have Medicare Part A	100 percent of poverty. Individual limit $851/mo. Couple limit $1,141/mo.	Resources below $4,000 for an Individual and $6,000 for a couple	Medicare Part B premium, deductible & coinsurance
(M) SLMB (52)	Must have Medicare Part A	135% of poverty ($1,149 for an individual and $1,540 for a couple).	Resources below $4,000 for an Individual and $6,000 for a couple	Medicare Part B premium
(M) LIF-LOW INCOME FAMILIES (58,59)	Must have child in home under age 18.	Gross income limit for family of four is $1,541/mo. Limit for family of four after child care and standard work deductions is $833/mo.	Resources at or below $30,000 per budget group	Medicaid
(M) SSI (80) (SUPPLEMENTAL SECURITY INCOME)	Aged (65+), blind, or totally and permanently disabled.	Individual limit $623/mo. Couple limit is $934/mo.	$2,000 for an Individual and $3,000 for a couple	Cash payment individual with no income receives $623/mo. Medicaid
(O) OPTIONAL SUPPLEMENT (85, 86)	Must live in a licensed residential care facility and meet SSI eligibility criteria except for income	Individual's net income limit is $1,056/mo.	$2,000 for an individual	Payment is difference between net income and $1056/mo. ($1003 for the facility, $53 for personal needs). Medicaid
(M) RIBICOFF (91)	Individuals under age 18.	Limit for family of four after child care and standard work deduction is $833/mo.	Resources at or below $30,000 per budget group	Medicaid
(O) SSI-RELATED MEDICAL ASST. ONLY (MAO) (10, 15, 54)	Aged (65+), blind or disabled. In a medical facility 30 days and meets intermediate or skilled nursing care criteria or receives home and community based "waivered" services.	Limit is $1,869/mo. Community spouse income allocation is $2,541.	$2,000 for an individual (excluding home) Community spouse resource $66,480	Medicaid/Individuals may be required to pay toward the cost of nursing services.

NOTE: (O) = Optional Coverage Group (M) = Mandatory Coverage Group

SOUTH CAROLINA STATE MEDICAID PROGRAM: MAJOR COVERAGE GROUPS (Effective 3/1/07)

	Eligible Population	Income Limits	Resources	Benefits
(O) FOSTER CHILDREN (60, 13)	Children under age 21, at least partially supported by the state, `living in foster homes or private institutions.	Limit is $408/mo.	Resources at or below $30,000 per budget group	Medicaid
(M) PREGNANT WOMEN & INFANTS UNDER 185% POVERTY (87)	Pregnant women and infants under age 1	For family of four limit after child care and other deductions is $3,184/mo.	Resources at or below $30,000 per budget group	Medicaid
(M) CHILDREN AGE 1-19 UNDER POVERTY (88)	All children ages 1-19 at or below 150% of poverty	Children age 1-19 in family of four limited to net income after child care and other deductibles of $2,581/mo.	Resources at or below $30,000 per budget group	Medicaid
(O) KATIE BECKETT/ TEFRA CHILDREN (57)	A disabled child age 18 or younger, residing at home, but needs ICF-MR facility, nursing facility, or hospital care.	Parent's income not counted. Child's limit is $1,869 per month.	Parent's resources not counted. Child's resources Limited to $2,000.	Medicaid
(O) WORKING DISABLED (40)	Under age 65, totally and permanently disabled and working.	Family income less than 250% of poverty. $2,127 per month for an individual. Individual's unearned income must be less than or equal to $623 per month	$2,000	Medicaid
(O) BREAST AND CERVICAL CANCER	Women ages 47-64 who have have been screened through Best Chance Network (BCN). Must be uninsured; or have insurance coverage with limited scope such as dental, vision or long term care; or exhausted lifetime benefits. Must require treatment for breast or cervical cancer or pre-cancerous lesions (CIN II and III) .	BCN income limit of 200% of poverty ($1,702)/mo.	No resource limit	Medicaid
(O) GAPS	Must be 65 or older.	Limit is 200% of FPL for an individual I($1,702/mo.)	No resource limit	After paying a monthly premium for their Prescription Drug Plan, GAPS participants will only have to pay 5% of the Prescription Drug Plan's costs between $2,400 and $5,451.25.

NOTE: (O) = Optional Coverage Group (M) = Mandatory Coverage Group

RSP Overlap Table

04/30/07

Code	AUTW	CHPC	CLTC	COSY	DMRE	DMRN	HIVA	PSCA	WAHS	VENT	HSCE	HSCN	ISED	MCPP	MCHS	MCHM	MCFC	MCNF	MCPC	SCCH	NHTR	MCCM
AUTW		x		x									x		x				x			x
CHPC	X			x							x	x	x	x		x						x
CLTC				x									x		x				x			x
COSY	X	x	x		x	x	x		x		x	x		x		x						x
DMRE				x									x		x				x			x
DMRN				x									x		x				x			x
HIVA				x									x		x				x			x
PSCA																						
WAHS				x									x	x		x						x
VENT															x				x			x
HSCE		x		x									x		x				x			x
HSCN		x		x									x		x				x			x
ISED	X	x	x		x	x	x		x		x	x		x		x						x
MCPP		x		x					x				x						x			
MCHS	X		x		x	x	x			x	x	x				x			x			x
MCHM		x		x					x				x		x				x			
MCFC																						
MCNF																						
MCPC	X		x		x	x	x			x	x	x		x	x	x						x
NHTR																						
MCCM	x	x	x	x	x	x	x		x	x	x	x	x		x				x	x		

Code	Ind	Proc Ind	Definition
AUTW	8	A	Autism Waiver
CHPC	H	C	CLTC Children's PCA
CLTC	A	E	CLTC Elderly Disabled
COSY	B	6	Cosy Project - Beaufort County
DMRE	M	5	DMR Waiver/Established
DMRN	L	5	DMR Waiver/New
HIVA	F	B	CLTC HIV AIDS
HSCE	S	H	Head and Spinal Cord/Established
HSCN	T	H	Head and Spinal Cord/New
ISED	I	6	Interagency Sys. of Care for Emot. Dist. Ch.
MCCM	5	-	Primary Care Case Management
MCFC	U	9	Medically Fragile Children's Program

Code	Ind	Proc Ind	Definition
MCHM	N	8	HMO
MCHS	K	7	Hospice
MCNF	W	9	Medically Fragile Non-Foster Care
MCPC	Z	-	Integrated Personal Care Services
MCPP	G	-	Physicians Enhanced Program
NHTR	4	N	Nursing Home Transition
PSCA	J	P	Palmetto Senior Care
VENT	V	V	CLTC Ventilator Waiver
WAHS	P	-	Waiver Healthy Start

1/19/07 Revised to remove SCCH per program area.
1/2/07 Revised to add overlap for 1915c Waivers to MCCM (per SW07002)
9/15/06 Revised to ADD AUTW (per SW 06031)
6/30/06 Revised to allow overlap between MCHM and MCHS (per SW06020)

SOUTH CAROLINA ASSESSMENT & LEVEL OF CARE MANUAL

FOR

MEDICAID-SPONSORED LONG TERM CARE SERVICES

Determination of medical necessity for Medicaid-sponsored long term care services is an important function. In order to assure that those persons who need long term care services receive them, there must be a thorough screening process. It is through this process that a written evaluation is conducted of an individual's medical, psychosocial, functional, environmental, support system and service needs. Following this evaluation, a recommendation can be made about the most appropriate, least restrictive environment where care can be provided to meet the individual's assessed needs.

As the state Medicaid agency, the Department of Health and Human Services (DHHS) is responsible by law for the development, promulgation, and oversight of criteria for determining medical necessity for both institutional and home and community-based long term care services.

This Assessment and Level of Care Manual for Medicaid-Sponsored Long Term Care Services contains the following documents:

- South Carolina Level of Care Criteria for Medicaid-Sponsored Long Term Care
- South Carolina Long Term Care Assessment Form (DHHS Form 1718)
- South Carolina Long Term Care Assessment Form User's Guide

Each of these tools have been carefully linked to one another in their application and use. Therefore, in order to effectively evaluate a long term care applicant, one must have a complete knowledge of all three and understand how each is relevant to the others.

For more information about the manual, call the Department of Health and Human Services' Division of Community Long Term Care (CLTC) at (803) 253-6142 or your local CLTC Area Office or write to:

State of South Carolina
Department of Health and Human Services
Division of Community Long Term Care
Post Office Box 8206
Columbia, South Carolina 29202-8206

South Carolina Level of Care Criteria
for
Medicaid-Sponsored Long Term Care

Eligibility for Medicaid-sponsored long term care in South Carolina consists of meeting established criteria. In addition to meeting general, categorical, and financial eligibility requirements, an individual must also meet medical or psychobehavioral and functional requirements as determined by a screening process.

During the screening process, a comprehensive assessment of the applicant is obtained using a standardized instrument. The attached level of care criteria are applied to determine whether an individual is eligible for skilled or intermediate care.

The criteria describe the minimum services and functional deficits necessary to qualify for Medicaid-sponsored long term care. The criteria are listed under two headings, skilled and intermediate. An individual is determined to be at a skilled or intermediate level of care upon meeting the criteria. Because no set of criteria can adequately describe all the possible circumstances, a knowledge of an individual's particular situation is essential in applying these criteria.

Skilled Level of Care

A person must need at least one of the numbered skilled services (Items 1-11, adapted from the Medicare requirements at 42 C.F.R. 409.32-35 [1993]) and have at least one of the numbered functional deficits listed below to qualify for skilled level of care. A person needing item #12 by itself qualifies for skilled level of care because this represents a total care individual. In order to qualify as a skilled service, the service must be ordered by a physician, require the skills of professional or technical personnel, and be furnished directly by or under the supervision of such personnel [42 C.F.R. 409.31-35 (1993).] The need for skilled services must be clearly documented in the client's record.

Skilled Services

1. Daily monitoring/observation and assessment due to an unstable medical condition which may include overall management and evaluation of a care plan which changes daily or several times a week.

2. Administration of medications which require frequent dosage adjustment, regulation, and monitoring.

3. Administration of parenteral medications and fluids which require frequent dosage adjustment, regulation, and monitoring. (Routine injection(s) scheduled daily or less frequently [such as insulin injection] do not qualify.)

4. Special catheter care (e.g., frequent irrigation, irrigation with special medications, frequent catheterizations for specific problems.)

5. Treatment of extensive decubitus ulcers or other widespread skin disorder. (Important considerations include: Signs of infections, full thickness tissue loss, or requirement of sterile technique)

6. A single goal-directed rehabilitative service (speech, physical, or occupational therapy) by a therapist 5 days per week. Combinations of therapies will satisfy this requirement.

7. Time-limited, goal-directed, educational services provided by professional or

technical personnel to teach self maintenance, such as education for newly-diagnosed or acute episodic conditions (e.g., medications, treatments, procedures).

8. Nasogastric tube or gastrostomy feedings.

9. Nasopharyngeal or tracheostomy aspirations or sterile tracheostomy care.

10. Administration of medical gases (e.g., oxygen) for the initial phase of condition requiring such treatment, monitoring, and evaluation (generally no longer than two week duration).

11. Daily skilled monitoring or observation for conditions that do not ordinarily require skilled care, but because of the combination of conditions, may result in special medical complications. In these situations, the complications and the skilled services required must be documented.

12. This individual is totally dependent in all activities of daily living: incapable of locomotion; unable to transfer; totally incontinent of urinary or bowel function; must be totally bathed and dressed and toileted and need extensive assistance to eat.

Functional Deficits

1. Requires extensive assistance (hands-on) with dressing and toileting and eating, and physical help in bathing. (All four must be present and, together, they constitute one deficit.)

2. Requires extensive assistance (hands-on) with locomotion.

3. Requires extensive assistance (hands-on) to transfer.

4. Requires frequent (hands on) bladder or bowel incontinence care; **or** with daily catheter or ostomy care.

Note: It may be determined that an individual without a required functional deficit has special medical needs. In such cases, the individual may have a skilled medical need that warrants on-going treatment and management, which can best be addressed with skilled nursing services.as outlined under skilled services (Pages 5-6, #1-11). These cases must be referred to the State Health and Human Services Finance Commission, Division of Community Long Term Care, for special review to determine the level of care.

Intermediate Level of Care

A person can meet the intermediate level of care criteria in either of two ways:

1. by requiring at least one of the four numbered intermediate services listed below **and** having one of the numbered functional deficits listed below;

OR

2. by having at least two of the numbered functional deficits listed below.

Intermediate Services

1. Daily monitoring of a significant medical condition requiring overall care planning in order to maintain optimum health status. The individual should manifest a documented need which warrants such monitoring.

2. Supervision of moderate/severe memory, either long or short term, manifested by disorientation, bewilderment, and forgetfulness which requires significant intervention in overall care planing.

3. Supervision of moderately impaired cognitive skills manifested by decisions which may reasonably be expected to affect an individual's own safety.

4. Supervision of moderate problem behavior manifested by verbal abusiveness, physical abusiveness, or socially inappropriate/disruptive behavior.

Functional Deficits

1. Requires extensive assistance (hands-on) with dressing and toileting and eating and physical help in bathing. (All four must be present and, together, they constitute one deficit.)

2. Requires extensive assistance (hands-on) with locomotion.

3. Requires extensive assistance (hands-on) to transfer.

4. Requires frequent (hands on) with bladder or bowel incontinent care; **or** with daily catheter or ostomy care.

South Carolina
Long Term Care Assessment Form
User's Guide

The South Carolina Long Term Care Assessment Form (DHHS Form 1718) is designed to gather necessary information about the medical, psychosocial, and functional status of a person to determine:

1. the level of care required to receive long term care services in a nursing facility or in a community setting and,

2. service planning needs for community cases.

It is the intent that each individual being evaluated for Medicaid-sponsored long term care be aware an application is being made and to be involved if possible in the assessment process.

The CLTC Consent Form (DHHS Form 121) must be read and signed before a nurse consultant can take any official action on the assessment. The form must be signed by a responsible relative only when the client is not competent or is physically unable to do so.

The assessment information should be obtained through an interview with and observation of the person being assessed (client). Other sources of information such as family members and medical records should be utilized as necessary.

Professional judgment is used in rating the individual's medical, psychobehavioral, and functional abilities.

The Omnibus Budget Reconciliation Act of 1987 requires states' Pre-Admission Screening programs and the Minimum Data Set to be coordinated so as to avoid duplication. The instruments (Form 1718 and the Resident Assessment Instrument) are similar and will allow the state to develop a statewide long term care data base for both nursing facility and community based clients.

The Form 1718 will be required for pre-admission screening for Medicaid-sponsorship of nursing facility care, nursing facility conversions in payment source (from Medicare, VA, private pay, etc.) to Medicaid, and referral to all CLTC waiver programs

(Elderly/Disabled Waiver, HIV/AIDS Waiver, etc.)

The 1718 has been cross-referenced to the Resident Assessment Instrument. The "codes" in each of the major lettered sections of the 1718 correspond to a similar section of the Resident Assessment Instrument. This will help nursing facility staff in the transfer of the corresponding codes from the 1718 to the Resident Assessment Instrument for new admissions. This will also provide a good base line for a resident new to the facility and staff. Use of the 1718 will further expedite the resident assessment and give base information to complete the Resident Assessment Instrument within the required 14 days. The 1718 will also provide pertinent information about the resident prior to institutionalization. Secondly, the 1718 will help the nursing facility with conversion cases. The cross-referenced codes will be used to transfer data that is unchanged from the Resident Assessment Instrument to the 1718.

Instructions for Completing the South Carolina Long Term Care Assessment Form

Black ink should be used to complete the Assessment Form, DHHS Form 1718. If the assessor is unable to obtain the information requested in an item, this should be noted in the appropriate comment section. Please remember that any missing information may delay the admission review process.

Instructions are given for completing each page. The 1718 has five sections These sections are as follows:

Section I. Identifying/Demographic Information
Section II. Medical Information
Section III. Functional Information
Section IV. Psychobehavioral Information
Section V. Environmental/Client Outcome Information

All comments should be dated to correspond with the appropriate assessment date.

Start with Column A initially and use Columns B, C, D, and E as changes and re-evaluations occur.

Completion of Section V is for use by CLTC staff only.

The Assessment Form must be completed by a nurse, social worker, social services worker, or physician. The nurse coordinator for resident assessments is encouraged to complete this form.

It is the intent that each individual being evaluated for Medicaid-sponsored long term care be aware the application is being made and be as involved as possible in the assessment process. The assessment information should be obtained through an interview with and observation of the person being assessed (client). Other sources of information such as family members and medical records should be utilized as necessary. It may be appropriate to have the client demonstrate functional ability.

The Mental Status Questionnaire (Section IV, Part N) should be completed early in the assessment process to assist in the determination of the client's cognitive state and an ability to provide accurate assessment information. The skilled assessor may incorporate the questions of the MSQ while gathering other assessment information

such as demographic data.
The assessment form (DHHS Form 1718) can be ordered by submitting a Request for Medicaid Forms and Publications (DHHS Form 142), or by a written request to:

Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
Attention: Support Services Supply Room

South Carolina Long Term Care Assessment Form
User's Guide

Section I - Identifying/Demographic Information

These pages can serve as a referral form for clients seeking home and community-based services when submitted separately without the accompanying pages. If information cannot be obtained for a section, reference these items in the general comments (Section V of the 1718). **Gray shaded areas are to be completed by CLTC staff only.**

1. **Application Date** - date the referral is processed.
2. **Intake Manager Code** - assigned code of nurse consultant intake worker.
3. **Reason for Referral** - select the appropriate category; if for conversion, put the requested effective date.
4. **Permanent Client Information** - fill out completely; use the four digit number for year of birth; if the information is unknown, leave blank.
5. **Present Location** - indicate where the person is when the referral is made, e.g., hospital, nursing facility, home, residential care facility; if present location is the same as permanent, indicate by marking "same as above" box. **Note**: Directions only need to be completed on a person located in the community.
6. **Responsible Party** - A family member or other individual actively involved in client's care.
7. **Demographic** - choose appropriate categories.
8. **Referral Type** - choose appropriate choice.
9. **Referral Mode** - choose appropriate choice.
10. **Intake Met** - choose appropriate choice.
11. **Reason for Referral** - Indicate functional dependency or other reason for referral.
12. **Referral Source** - complete all sections.
13. **Referral Location** - Indicate where the client is located at the time of the referral.
14. **Assessment Referred To** - Indicate who is to complete the 1718.
15. **Physician Information** - give the name of the physician responsible for continuing care in the community or nursing facility; this may be a different physician than the one caring for the client while in the hospital.
16. **Financial** - complete appropriately.
17. **Signature** - Signature of person completing Section I of the 1718. (Note: only

a nurse, social worker, social services worker, or physician may complete and sign this form.)

Section II - Medical Information

This section contains current information on diagnoses, stability of condition, abnormal data, treatments and therapies, nutritional/diet regime, medications and height/weight.

A. Diagnoses - categorized in the following groups:

Heart/Circulation
Sensory
Neurological
Psychiatric/Mood
Pulmonary
Skin Condition
Other
HIV/AIDS

Coding: Indicate only the diseases present that have a relationship to current ADL status, medical treatments, or risk of death. Do not include conditions that have been resolved or no longer affect the client's functioning or care plan.

Example 1:

Code 1 = current/new (example: Diabetes Mellitus or if client has had CVA and has residual effect.)

Example 2:

Code 2 = discontinued/past history not currently treated (example: Pneumonia)

Example 3:

If a client is a quadriplegic as a result of a head injury, indicate a "1" by the diagnosis of head injury and quadriplegia.

Skin Condition: If the client has decubiti, indicate "yes" or "no", then indicate the stage in the columns as 1, 2, 3, or 4.

Stage 1 - A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
Stage 2 - A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
Stage 3 - A full thickness of skin loss, exposing the subcutaneous tissues; presents as a deep crater with or without undermining adjacent tissue.
Stage 4 - A full thickness of skin and subcutaneous tissue is lost, exposing muscle and bone.

Note: If the client has more than one decubiti, put the stage of the worst in the column and describe others in general comments.

Other: There is space available to indicate any allergies at the time of the initial assessment since these are not likely to change or need updating.

For any diagnoses not listed, use the "aaa-Other" area. Please write in the diagnoses in the space provided.

If the client is diagnosed with AIDS, indicate "bbb". If the client is HIV+, mark "ccc" and list the specific related conditions reported on the lines below. The most recent CD4 count should be indicated.

B. Stability of Condition

The intent of this item is to determine the current health status in relation to diseases/conditions present during the last 7 days, noting whether the client experiences an unstable condition and/or an acute condition episode or a flare-up of a recurrent/chronic problem.

Coding: Check **all** that apply during the last 7 days. If none apply, check item "C-None of the Above".

Examples: The item A should be used for a diabetic who requires daily or more frequent blood sugar tests in conjunction with administering sliding-scale insulin dosages. This client becomes confused when hypoglycemic. If this same client had pneumonia at the time of assessment, code item A for Unstable and item B for Acute. If a diabetic receives NPH Insulin 20 units sq QAM, requires monthly

blood sugar determinations, and has no current acute illness, code item C-None of the Above.

C. Abnormal Data

The intent of this item is to record whether the client had any known abnormal data, either lab data (i.e., blood sugar, drug levels) or abnormal vital signs during the prior 90-day period. The abnormal lab data refer to lab values that are abnormal when compared to standard values, not abnormal for the specific client.

Coding: Use the space provided to record any abnormalities and date each entry.

If no abnormal data is known, indicate in field "n/a".

D. Treatments and Therapies

The intent of this section is to identify the frequency of all treatments and therapies that the client is receiving.

Coding: Frequency codes are provided in the Section H-Medications. If the client receives no treatments or therapies, check item U-None of the Above.

For any treatments or therapies not listed, use the "T-Other" area and specify in the comments field any additions in the space provided.

E. Nutritional Approaches and Special Diets

The intent of this item is to identify nutritional approaches and specify special dietary needs.

Coding: Check **all** that apply in the appropriate alphabetical column. If the client receives no special nutritional approaches or special diet, check item T-None of the Above.

For any nutritional approaches or special diet not listed, use the "S-Other" area. Please annotate any additions in the space provided.

Note: Wasting indicates a general debilitating, weak state characterized by a

weight loss of greater than 10% in the last 60 days and resulting in a noticeable loss of muscle tone. This may be caused by an underlying disease state, i.e., HIV, cancer. Comment on weight gain or loss as appropriate in the comments section.

Nutritional Screening: This section must be completed on an applicant applying for CCM (E/D, HIV, Vent) upon the initial evaluation and re-evaluation. Completion is optional for other applicants (NH, TEFRA, etc.) Indicate all that apply to the applicant. For questions 3, 9, and 10, if any of the phrases are indicated, the entire amount of points are assigned. CMS will automatically score this section. The comment section can be used as needed.

F. Skin

The intent of this item is to record the client's current skin condition. Check as appropriate.

G. Height/Weight

Initially code the height and weight. On updates and reassessments, record only the weight, since height is not likely to vary for adults. Height and weight should be recorded on re-evaluations of clients less than 18 years old.

Note: For bilateral amputees, use pre-op height.

H. Medications

The intent of this item is to record the client's current medication use.

Coding: List the name and dosage of each drug the client is currently taking, followed by the route of administration and frequency (refer to the codes on the assessment). There is also a column for the discontinuation date of medications previously recorded on the form that are no longer current. If over eight medications are listed, complete Page 10 of the 1718. If more explanation is needed, annotate in the comments section.

There is an area to be used to annotate any medication which requires frequent monitoring or adjustment. Code O if "no" and Code 1 if "yes". If "yes" is coded, describe in the space provided.

Grid

This section should be completed by the assessor to indicate the date, the assessor's initials and the source of the medical information, utilizing the source codes provided on the form. The initial assessment will be completed using Column A. All subsequent updates and reassessments should be recorded in the next available alphabetical grid.
Signature

The initial assessor should also sign the form and complete the space to indicate his/her title and the date Section II was completed.

Section III - Functional Information

I. Activities of Daily Living Coding Instructions

In this section, the client's self-care performance in activities of daily living is evaluated. Use the ADL Self-Performance categories at the top of page 8 to code the ADL's: transfer, locomotion, dressing, eating, and toilet use. Separate coding categories are used for bathing and continence. The ADL self-performance categories measure what the client actually did without assistance in the last 7-14 days, indicating balance between client's self-performance and assistance caregivers provided for each activity. The assessor should use professional judgment to determine if the last 7-14 days are representative of the client's overall ADL ability. Note that codes 0, 1, 2, 3 permit one or two exceptions where heavier care is provided. This "exception" aspect of ADL codes is useful to ensure that the client is not assigned to an excessively dependent category and to increase the likelihood that the ADL items will be coded consistently and accurately.

Definitions for each of the ADL categories are included on the 1718 to guide the assessor when evaluating the client's performance in each category. Use the Comments Section to clarify or describe situations, as needed.

Note: To determine the applicable functional description for children under eighteen, the reviewer should refer to the attached guide of developmental stages of children. Code each functional activity with regard to age appropriateness. Example: A 3-month old cannot ambulate. The reviewer would code as "O" and comment "inability to ambulate is age appropriate".

Codes

Independent - Indicates the client is totally capable of completing the activity without assistance. The client can also be coded as "0" if the client received minor assistance or supervision only one or two times over the past 7 days due to special circumstances, but completed the activity independently all other times for that week. Example: Mr. U goes out one day a week to visit with family and returns in a fatigued state. He then requires help undressing prior to going to bed. He required no help that morning in dressing, and was fully self-sufficient on all other days in dressing and undressing. Thus, over the 7-day assessment period, Mr. U was fully self-sufficient 13 times and required hands-on help one time. Based on careful clinical review, the ADL codes permit this resident to be coded "O" for "Independent" in dressing.

Supervision: Indicates the client is capable of completing the activity independently with only supervision, cuing (reminders), or encouragement. **Note**: For continuous step by step instruction - see Extensive Assistance.

The client can also be coded a "1" if receiving Supervision and Limited Assistance (see code #2) only one or two times during the last 7 days, but completed the activity independently with only oversight, encouragement, or cuing (reminders) all other times for that week.

Limited Assistance - Indicates the client is capable of completing the activity with only minor assistance from caregivers.

The client can also be coded a "2" if the client received extensive assistance (see code #3) less than 50% of the time, but was capable of completing the activity with only minor assistance all other times for that week.

Extensive Assistance - Indicates the client can complete part of the activity but needs human assistance (hands-on) or verbal directions (continuous step by step direction) in relation to the activity 50% or more of the time.

The client can also be coded a "3" if receiving total assistance with the activity less than 50% of the time, but was capable of completing part of the activity all other times for that week. (Indicates hands-on assistance

needed at least 50% of the time.)

Total Dependence - Indicates the client was totally unable to assist in the activity all 7 days.

Definitions

Transfer

Indicates how the client moves between surfaces, i.e. to/from bed, chair, wheelchair, standing position (excludes to/from toileting.)

0 - **Independent** - Indicates total independence in transferring. If an assistive device is used, the type of device should be identified in the comments section.

1 - **Supervision** - Indicates that even though the person is independent is transferring, standby supervision and/or direction is necessary for safety.

2 - **Limited Assistance** - Indicates direction or guidance is needed for correct positioning of limbs/appliances (, sliding board), for safety, but client can transfer self.

3 - **Extensive Assistance** - Indicates hands-on assistance or continuous step by step direction is necessary for transfer; weight bearing includes few weight bearing steps with pivot.

4 - **Total Dependence** - Indicates transfer requires total human support; non-weight bearing or only able to pivot.

If during the assessment, a transfer deficit is the only identified self-performance problem, the effects of the transfer deficit on all other activities of daily living should be carefully evaluated. **Example**: If the client uses a lift chair, assess the ability to transfer from bed, toilet, etc.

Locomotion

Includes ambulation and wheelchair (electric or manually propelled) performance. A client's environment should be considered when evaluating this ADL. A client's endurance should be considered when evaluating ability to walk or propel a wheelchair.

0 - Independent - Indicates total independence in walking, in wheelchair, or in motor cart (i.e., client who is completely mobile in electric wheelchair). If an assisting device is used, the type of

device should be identified in the comment section (i.e., walker, cane).

1 - Supervision - With or without assistive device indicates intermittent supervision may be needed with ambulation or wheelchair use. Example: Slow gait but steady.

2 - Limited Assistance - Indicates guidance is needed for correct positioning of limbs/appliances (e.g., braces, prosthesis) or assistance is needed in difficult wheelchair/ambulation maneuvers (awkward thresholds, crowded areas, elevators/stairs, uneven pavement, outside) or for safety with ambulation/wheelchair. The client has the capacity to ambulate or propel wheelchair independently to a destination (more than 20 feet).

3 - Extensive Assistance - Indicates the need for physical assistance with ambulation; this need, including unsteadiness with ambulation, assistance with the application of a brace or prothesis without which a client could not walk. If a client is wheelchair bound, indicates physical or verbal support is needed for wheelchair use.

It also indicates necessary extensive continuous verbal/hands-on direction to prevent wandering, whether because of the client's habitual tendency or his/her inability to find strategic locations (i.e., bathroom, dining room). Definition: Wandering indicates non-goal directed locomotion.

4 - Total Dependence - Indicates a client's total inability for walking, even though the ability remains to stand and bear weight or, if wheelchair bound, indicates total inability to operate or manually propel the wheelchair.

Dressing

Assessment should focus on the client's ability to dress self.

0 - **Independent** - Indicates the client is totally capable of dressing without assistance.

1 - **Supervision** - Indicates oversight or reminders are needed for dressing.

2 - **Limited Assistance** - Indicates help is needed with zippers, buttons, shoes, laying out of clothes, etc.

3 - **Extensive Assistance** - Indicates the client needs physical assistance or continuous verbal step by step directions in relation to appropriate dressing at least 50% of the time.

Such assistance may be needed by a client who frequently dresses inappropriately for the physical environment (i.e., many layers of clothes when the temperature does not warrant them).

4 - **Total Dependence** - Indicates the client must be dressed by others.

Eating

Code appropriately relative to the activities the client is capable of accomplishing within a reasonable length of time for a meal. The amount of food consumed in order to ensure adequate nutritional intake should also be considered.

Outside a long term care facility, "setting up the meal" is defined as a person's ability to take prepared food, warm it and serve it for eating. Since these activities would not be appropriate in nursing facilities or residential care facilities due to licensing and certification standards, staff of the facility should evaluate the client's ability to accomplish these activities.

0 - **Independent** - Indicates no assistance is needed in setting up and eating the meal. Setting up the meal is defined as a person's ability to take prepared food, warm it, and serve it for eating.

1 - **Supervision** - Indicates oversight or reminders are needed for meal preparation and/or to eat meals.

2 - **Limited Assistance** - Indicates help is needed in cutting meat, opening prepackaged items, and so forth.

3 - **Extensive Assistance** - Indicates the need for physical assistance with or continuous step by step directions pertaining to eating and/or setting up the meal at least 50% of the time.

4 - **Total Dependence** - Indicates the client is totally dependent on another for feeding.

Toilet Use

Indicate how the client uses the toilet (i.e. commode, bedpan, urinal): transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.

If bowel/bladder training is in progress, indicate this in the comment section of the continence section. If toileting is done at bedside, using bedpan or commode, indicate in the comments section if the client has any measure of independence.

0 - **Independent** - Indicates that no assistance is required for toileting.

1 - **Supervision** - Indicates oversight is needed for safety in toileting.

2 - **Limited Assistance** - Indicates help is needed with arranging clothes or emptying bedpan/bedside commode.

3 - **Extensive Assistance** - Indicates routine physical or continuous step by step direction for transfer and/or personal hygiene. This may include a person who frequently toilets in inappropriate places (i.e., floor vents, dresser drawers).

4 - **Total Dependence** - Indicates total assistance.

Bathing

This activity rates the maximum amount of physical assistance the client requires in order to achieve safe and adequate hygiene. Code the maximum amount of assistance client receives. Physical help in part of bathing activity (washing off) indicates that client needs assistance in a part of the bathing activity at least 50% of the time (excludes washing of back and hair.)

0 - **Independent** - Indicates no physical assistance or direction is needed with routine daily bathing.

1 - **Supervision** - Indicates standby oversight or supervision is necessary to ensure safety and completion, regardless of method of bathing.

2 - **Physical Help Limited to Transfer Only** - Indicates physical assistance is needed to move from one surface to another (example: getting in and out of tub/shower), but no assistance is needed with bathing activity or assistance needed less than 50% of the time (excludes washing of back and hair).

3 - **Physical Help in Part of Bathing Activity** - Indicates necessity hands on physical assistance or continuous step by step direction is needed in bathing 50% or more of the time (excludes washing of back and hair).

4 - **Total Dependence** - Indicates total hands-on assistance is required in bathing.

Continence

These categories are to be used to code the pattern of bladder and bowel continence/control during the last 14-day period. Use the codes provided on the 1718, Page 8-Continence.

0 - Indicates complete control. **Note**: This would be counted as a deficit when indwelling catheter is in place and not self care.

1 - For bladder-Indicates incontinent episodes once a week or less; For bowel-Indicates less than weekly

2 - For bladder-Indicates 2+ times a week but not daily; For bowel-Indicates once a week.

3 - For bladder-Indicates frequent incontinence, but some control, **OR** if the client is being toileted (extensive assistance) on a regular basis,

i.e., every 2 hours; For bowel-Incontinent 2-3 times a week.

4 - Indicates total incontinence and no control (or an indwelling catheter/ostomy that controls the client's bladder/bowel (without leakage).

Use of appliances and/or self-care should be indicated by an "N" or "Y" in the appropriate box(es) on the 1718.

Note: If the client is incontinent, but self-care indicated, this does not constitute a deficit.

J. Modes of Transfer - Select all that apply.

K. Modes of Locomotion - Select all that apply.

L. Appliance/Programs - Select all that apply.

M. Communication

Select the appropriate description and indicate by placing the corresponding number in the appropriate box by each of the four categories. Comment on any prosthesis and/or appliances the client uses.

Modes of Expression: Indicate all that apply.

N. Vision

Select the appropriate description and indicate by placing the corresponding number in the column Comment on any prosthesis and/or appliances the client uses.

Section IV - Psychobehavioral Information

Note: For children under age twelve, completing of this section is not required but comments should be made. Briefly describe the behavioral manifestations of daily habits or psychological problems. The assessor is not diagnosing, but reporting observable behavior.

O. Cognitive Patterns

Comatose

Indicates a state of unconsciousness from which a client cannot be aroused by verbal or light tactile stimuli; no communication skills.

Record the appropriate number in the box. If a client is comatose, enter "1", then STOP Section IV here.

Memory

Coding for this section:

0 - No problem to minimal problem
1 - Moderate to severe problem
2 - Unable to rate

Short-term memory - Ask the client to describe a recent event. For example, ask the client to describe the breakfast meal, an activity just completed, or object recall, and rate accordingly using the appropriate number.

Long-term memory - Engage in conversation that is meaningful to the client. Ask questions for which you already know the answers (from your review of record, general knowledge, family.) For example, "Are you married?", "What is your spouse's name?", "Do you have any children?", "How many?", "When is your birthday?". Rate accordingly.

If the client has a moderate/severe problem, comment as to the degree of the problem and cite an example in the comments section.

Cognitive Skills for Daily Decision Making (Judgment)

Select appropriate description and code.

0 - **Independent** - The client's decisions are consistent and reasonable, reflecting lifestyle, culture, values. The client organizes daily routine and makes decisions in a consistent, reasonable, and organized fashion.

1 - **Modified Independence** - The client organizes daily routine and makes safe decisions in familiar situations, but experiences some difficulty in decision making when faced with new tasks or situations.

2 - **Moderately Impaired** - The client's overall decisions are poor. The client requires reminders, cues, and supervision in planning, organizing, and correcting daily routines. Note: Cite an example in the Comments Section.

3 - **Severely Impaired** - The client's overall decision making is severely impaired. The client never (or rarely) makes decisions. Note: Cite an

example in the Comments Section.

P. Mood and Behavior Patterns

Select the code that most appropriately describes:

Sad or Anxious Mood - This behavior **pattern** presents as distressed mood characterized by explicit verbal or gestural expressions of feeling depressed or anxious (or a synonym such as feeling sad, miserable, blue, hopeless, empty, or tearful.) **Note**: Specify behavior in the comments section.

Problem Behavior - Four categories are listed. Code appropriate categories and specify behavior in the comments sections. Comment on past behavior if pertinent to current condition.

Q. Mental Status Questionnaire

Code as appropriate. The total MSQ score is the number of incorrect answers. **Note**: The MSQ is to be used only for a client 12 years or older.

R. Comments

Record pertinent additional information and date each entry.

Signature of Person Completing the Assessment Form

The individual who completes the initial assessment form must sign and date the form and indicate his/her title in the space provided at the end of Section IV. Only nurses, social workers, social service workers, or physicians may complete this form.

Grid

Place the date the corresponding column was completed and the initials of the person completing the form. **Gray Grid is for CLTC use only.**

Section V - Environmental/Client Outcome Information - CLTC Use Only

This section is to be completed by the CLTC nurse consultant and case manager.

Instrumental Activities of Daily Living and Residence will be completed only on community case management cases upon initial assessment and at re-evaluation.

S. Client Outcomes

Client outcome information will be annotated on all clients. Enter the date of action that the client entered the CLTC program or terminated. Use the code to indicate which CLTC program entered or the termination codes to show the reason for termination.

T. Nursing Facility Certification

Circle the appropriate level of care and annotate the effective date and expiration date of certification. Certifications are issued for 30 days unless a time-limited certification is given. If this is the case, the end date of the time-limited certification is the expiration date. Circle the appropriate response to indicate if the certification is time-limited and the name of the nursing facility, if known.

U. Instrumental Activities of Daily Living

Instrumental Activities of Daily Living will be completed only on community case management cases upon initial assessment and at re-evaluation.

Using the codes 1 = Independent, 2 = Some Assistance, and 3 = Dependent, respond to the 7 items that relate to the client's ability to perform instrumental ADL's. Use the comments section if further explanation is needed for clarification of an entry. Example: Medication - If coded limited assistance, an example comment would be "medications require set up".

V. Residence

This Section will be completed only on community case management cases upon initial assessment and re-evaluation. Using the codes 1 = yes and 2 = no, respond to the nine items that relate to environmental factors which relate to the client's residence. Use the Comments Section if further explanation or clarification is needed.

Guide to Developmental Stages of Children

1 Month
- Eyes follow bright moving object
- Responds to noises
- Makes throaty noise
- Makes crawling movements when prone
- When held in standing position, body limp at knees and hips
- In sitting position back is uniformly rounded, absence of head control

2 Months
- Turns from side to back
- Begins to lift head, smiles
- Some eye coordination, follows sounds
- Anticipates being fed, put hands in mouth
- When prone, can life head almost 45 degrees off table
- When held in sitting position, holds head up but head bobs forward

3 Months
- Holds head high, makes crawling movements when prone
- Has fairly good head control, turns head to follow people
- Holds objects in hands
- Smiles, coos
- Focuses and follows objects
- Able to hold head more erect when sitting, but still bobs forward
- When held in standing position, able to bear slight fraction of weight on legs

4 Months
- Laughs, cries for attention
- Rolls from back to side
- Listens, turns head to sound
- Holds objects, takes to mouth
- Sleeps through the night, has naptime
- Recognizes mother, responds to "no"
- Able to sit erect if propped up

6 Months
- Sits in high chair with back straight
- When held in standing position, bears almost all of weight

7 Months
- 2 central lower incisors
- Double birth weight
- Bears full weight on feet
- Rolls over easily
- Starts to talk "Ma" "Da"
- Laughs
- Frets when mother leaves
- When held in standing position, bounces actively

8 Months
- Sits steadily un supported
- Readily bears weight on legs when supported, may stand holding on

9 Months
- Crawls, may progress backward at first
- Sits steadily on floor for prolonged time (10 minutes)
- Pulls self to standing position and stands holding onto furniture

10 Months
- Sits without support
- Pulls self up
- Can hold bottle and feed self crackers
- Claps hands
- Can drink from cup
- 4 upper incisors
- Crawls by pulling self forward with hands
- Pulls self to sitting position
- Stands while holding onto furniture, sits by falling down

12 Months
- Shows anger, fear, affection
- Triple birth weight
- Begins to stand alone and toddle
- Has 2 lower incisors
- Uses spoon
- Builds blocks (2)
- Tries to toss objects
- Has regular B.Ms.
- Attention span increases
- Cruises or walks holding onto furniture or with both hands held
- Walks with one hand held
- May attempt to stand alone momentarily
- Can sit down from standing position without help

15 Months
- Walks without help (usually since age 13 months)
- Creeps up stair
- Assumes standing position without support
- Uses cup well but rotates spoon
- Feeds self using regular cup with little spilling

18 Months
- Runs clumsily, falls often
- Walks upstairs with one hand held
- Seats self on chair
- Manages spoon without rotation, but some spilling
- Takes off gloves, socks, and shoes and unzips

24 Months
- Uses short sentences
- Obeys simple commands
- Walks up and down stairs, has steady gait
- Holds cup for drinking
- Feeds self with spoon
- Kicks ball, builds 4 to 6 block tower
- Rides tricycle
- Uses "mine - no" words
- Resists bedtime
- Cooperates with toilet training
- Clings to parents
- Routine is important
- Has 4 cuspids
- Runs fairly well, with wide stance
- Dresses self in simple clothing

3 Years
· Plays with others - takes turns
· Colors
· Begins 5 lb. weight gain per year
· Rides tricycle, dances, jumps, swings and climbs
· Knows and gives full name
· Talks in short sentences
· Undresses self, washes and dries hands
· Feeds self with spoon
· Begins to handle short separation from parents
· Begins to identify genders
· Jumps with both feet
· May attend to toilet needs without help except for wiping
· Goes up stairs using alternate feet, may still come down using both feet on the step
· Buttons and unbuttons accessible buttons
· Pulls on shoes

4 Years
· Buttons front and side of clothes
· Adds 9-10 inches to height
· Laces shoes
· Baths self with directions
· Brushes teeth
· Climbs and jumps well
· Tries to print letters
· Learns some numbers, colors
· Asks many questions and uses language
· Performs simple tasks
· Keen observer
· Skips andhops on one foot
· Walks down stairs using alternate footing

5 Years
· Gains 7 lbs.per year (varies)
· Has good motor control
· Washes self
· Height increases 2½ inches per year (varies)
· Prints first name and other words
· Talks constantly
· Participates in conversations, asks for definitions
· Begins to lose baby teeth; permanent teeth appear about 4 per year from 7-14 years
· Knows age and residence
· Knows weeks, days of week, colors
· Counts to 10, can copy a triangle
· Is obedient, reliable and sympathetic
· Eyes become fully developed
· Protective toward younger children
· Accepts responsibility for actions, is less rebellious
· Shares toys
· Skips and hops on alternate feet
· Balances on alternate feet with eyes closed
· Ties shoelaces
· Cares for self totally, occasionally needing supervision in dress or hygiene
· Has full set of teeth (20)
· 4 second molars